b. Extensive service category.

(1) To qualify for the extensive services category, a resident must have:

(a) Within the fourteen days preceding the assessment, received intravenous medication in the facility or tracheostomy care or required a ventilator, respirator, or suctioning; or

(b) Within the seven days preceding the assessment, received intravenous feeding; and

(2) A resident who qualifies for the extensive services category must have assigned a qualifier score of zero to five based on:

(a) The presence of a clinical criteria that qualifies the resident for the special care category, clinically complex category, or impaired cognition category;

(b) Whether the resident received intravenous medications or intravenous feeding while in the facility;

(c) Whether the resident received tracheostomy care and suctioning; or

(d) Whether the resident required a ventilator or respirator.

c. Special care category.

(1) To qualify for special care category, a resident must have at least one of the following conditions or treatments:

(a) Multiple sclerosis, cerebral palsy, or quadriplegia with an activities of daily living score of at least ten;
(b) Respiratory therapy seven days a week;
(c) Treatment for pressure or stasis ulcers on two or more body sites;
(d) Surgical wound or open lesion with treatment;
(e) Tube feedings that comprise at least twenty-six percent of daily calorie requirements and at least five hundred and one milliliters of fluid through the tube per day, and be aphasic;
(f) Radiation therapy; or
(g) A fever in combination with dehydration, pneumonia, vomiting, weight loss or tube feeding.

(2) A resident who qualifies for the special care category is assigned a subcategory based on the resident's activities of daily living score.

d. Clinically complex category.

(1) To qualify for the clinically complex category, a resident must have at least one of the following conditions, treatments, or circumstances:

(a) Comatose;
(b) Burns;
(c) Septicemia;
(d) Pneumonia;
(e) Internal bleeding;
(f) Dehydration;
(g) Dialysis;
(h) Hemiplegia with an activities of daily living score of at least ten;
(i) Chemotherapy;
(j) Tube feedings that comprise at least twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day;
(k) Transfusions;
(l) Foot wound with treatment;
(m) Diabetes mellitus, with injections seven days per week and two or more physician order changes in the fourteen days preceding the assessment;
(n) Oxygen therapy in the fourteen days preceding the assessment; or
(o) Within the fourteen days preceding the assessment, at least one physician visit with at least four order changes or at least two physician visits with at least two order changes.

(2) A resident who qualifies for the clinically complex category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

e. Impaired cognition category. To qualify for the impaired cognition category, a resident must have a cognition performance scale score of three, four, or five and an activities of daily living score of less than eleven. A resident who qualifies for the impaired cognition category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

f. Behavior only category.

(1) To qualify for the behavior only category, a resident must have exhibited, in four of the seven days preceding the assessment, any one or more of the following behaviors:

(a) Resisting care;

(b) Combativeness;
(c) Physical abuse;
(d) Verbal abuse;
(e) Wandering; or
(f) Hallucinating or having delusions.

(2) A resident who qualifies for the behavior only category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

g. Reduced physical functioning category. To qualify for the reduced physical functioning category, a resident may not qualify for any other category. A resident who qualifies for the reduced physical functioning category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

7. Except as provided in subsection 2, each resident must be classified into a case-mix class with the corresponding group label, activities of daily living score, other criteria, and case-mix weight as follows:

Group	Classification Category	ADL Score	Qualifier Score	Nursing Rehabilitation	Signs of Depression	Relative Weight
RAD	Rehabilitation	17-18				1.79
RAC	Rehabilitation	14-16				1.54
RAB	Rehabilitation	9-13				1.26
RAA	Rehabilitation	4-8				1.07
SE3	Extensive Services	7-18	4-5			2.62
SE2	Extensive Services	7-18	2-3			1.72
SE1	Extensive Services	7-18	0-1			1.56
SSA	Extensive Services	4-6	0-5			1.33
SSC	Special Care	17-18				1.50
SSB	Special Care	15-16				1.39
SSA	Special Care	7-14				1.33
CA1	Special Care	4-6				1.02
CC2	Clinically Complex	17-18			Yes	1.46
CC1	Clinically Complex	17-18			No	1.27
CB2	Clinically Complex	12-16			Yes	1.18
CB1	Clinically Complex	12-16			No	1.17
CA2	Clinically Complex	4-11			Yes	1.08
CA1	Clinically Complex	4-11			No	1.02
IB2	Impaired Cognition	6-10		Yes		0.98
IB1	Impaired Cognition	6-10		No		0.88
IA2	Impaired Cognition	4-5		Yes		0.80
IA1	Impaired Cognition	4-5		No		0.67
BB2	Behavior Only	6-10		Yes		0.97
BB1	Behavior Only	6-10		No		0.85
BA2	Behavior Only	4-5		Yes		0.69
BA1	Behavior Only	4-5		No		0.63
PE2	Reduced Physical Functioning	16-18		Yes		1.04
PE1	Reduced Physical Functioning	16-18		No		0.96
PD2	Reduced Physical Functioning	11-15		Yes		0.95
PD1	Reduced Physical Functioning	11-15		No		0.87
PC2	Reduced Physical Functioning	9-10		Yes		0.86
PC1	Reduced Physical Functioning	9-10		No		0.84
PB2	Reduced Physical Functioning	6-8		Yes		0.75
PB1	Reduced Physical Functioning	6-8		No		0.68
PA2	Reduced Physical Functioning	4-5		Yes		0.66
PA1	Reduced Physical Functioning	4-5		No		0.62

8. The classification is effective the date the resident assessment period ends in all cases except an admission or for a return from an acute hospital stay. The classification for an admission or for a return is effective the date of the admission or return.

9. A facility complying with any provision of this section that requires a resident assessment must use the minimum data set in a resident assessment instrument that conforms to standards for a resident classification system described in 42 CFR 413.333.

Section 33 - (Vacated)

Section 34 - (Vacated)

Section 35 - Resident Personal Funds

1. A facility may not require residents to deposit personal funds with the facility.

2. Upon written authorization of a resident or the resident's legal representative, a facility must hold, safeguard, manage, and account for the resident's personal funds deposited with the facility.

3. The facility may not charge the resident for holding, safeguarding, managing, or accounting for the resident's personal funds. Any related administrative costs, including bank charges, must be included in the daily rate. The facility may not impose a charge against a resident's personal funds for any item or service which is included in the daily rate.

4. The facility may maintain a resident's personal funds that do not exceed fifty dollars in a non-interest bearing account. The facility must deposit any resident's personal funds in excess of fifty dollars in an interest bearing account that is separate from any of the facility's accounts and that credits all interest earned on the resident's account to such account.

5. The facility must maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds. An individual financial record must be available on request and a written accounting of transactions must be provided quarterly to the resident or the resident's legal representative.

6. Resident personal funds may not be commingled with any facility funds or with funds of any person other than another resident.

7. Upon death of a resident, the facility must promptly convey the resident's personal funds, and a final accounting of those funds, to the individual administering the resident's estate. For purposes of this section, an "individual administering the resident's estate" includes a person lawfully empowered to facilitate the transfer of small estates without the use of a personal representative.

8. The facility must purchase a surety bond or provide self-insurance to assure the security of all resident personal funds deposited with the facility.

Section 36 - Specialized Rates for Extraordinary Medical Care

1. A specialized rate for an individual with extraordinary medical needs may be established if the criteria in both subdivisions a and b are met.

   a. (1) The individual requires specialized therapies that are:

      (a) Restorative in nature (restorative means the individual has the ability to improve);

      (b) Medically necessary and provided in the facility;

      (c) Of at least two different types; and

      (d) Provided in excess of fifteen hours per week;

   (2) The individual requires extensive pulmonary care resulting from:

      (a) Suctioning and related tracheostomy care performed by a licensed nurse or therapist in excess of three and one-half hours in a twenty-four hour period; or

      (b) A drug-resistant respiratory infection;

   (3) The individual requires total parenteral nutrition (TPN) and:

      (a) The individual is not eligible for or has been denied medicare part A or B benefits; and

      (b) The individual requires total parenteral nutrition based on medical necessity for a minimum of three months; or

   (4) The individual requires the use of a ventilator and:

      (a) Is dependent on the ventilator a minimum of six hours per day;

      (b) Requires direct care by a licensed nurse, nurse aide, or therapist on a daily average of nine hours per day;

      (c) Is physiologically stable; and

      (d) Attempts to wean the individual from the ventilator have occurred during the acute hospital stay.

b. Costs to provide direct care to the individual for the specialized services must exceed two and one-quarter times the actual direct care rate, adjusted for inflation, prior to limitations, for the individual's resident classification, except the department may use a cost limitation of one and three-quarters times the actual direct rate, if specialized equipment is purchased for use by the resident. Costs which may be included in determining if the cost factor is exceeded include salaries and fringe benefits of all direct care staff, nursing supplies, drugs, dietary supplements, and specialized equipment costs.

2. A specialized rate will be calculated for an individual who meets the criteria by subtracting the actual cost per day for direct care, prior to limitations, for the individual's classification from the total cost per day for the individual.

3. Except as provided for in subsection 7, all income received for a specialized rate must be offset proportionately to the affected cost categories.

4. The facility must report costs on a monthly basis for the first three full months after admission and on a quarterly basis thereafter. The specialized rates will be adjusted to actual on a prospective basis based on the report submissions.

5. The specialized rate will be paid in addition to the rate established for the individual's resident classification and may only be paid for in-house resident days.

6. A one-time startup cost of $1,000 must be included in the initial specialized rate for the first thirty days after the effective date of the specialized rate.

7. If a specialized rate has been established and costs to provide direct care to the individual decrease to less than the cost limits provided for in subdivision b of subsection 1, the specialized rate must continue until the end of the rate year. Income from the specialized rate may not be offset to reported costs for the report year in which the costs to provide direct care to the individual decreased to less than the established cost limits.

APPENDIX A

TRANSMITTAL NO. 92-003
Date Approved 10/14/92
Effective Date 1/1/92
Supersedes Transmittal 90-04

TRANSMITTAL NO. 92-003
Date Approved 10/14/92
Effective Date 1/1/92
Supersedes Transmittal